

**Latino
Task Force Report
on the Year 2000
Health Promotion Objectives
and
Recommendations
for California**

May 1992

Prepared by the Latino Task Force for the
Unity in Health, Diversity in Culture Conference, sponsored by the
California Department of Health Services Health Promotion Section
in June 1991.

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The comments and recommendations expressed in this report are of the Latino Task Force and do not necessarily reflect the activities or plans of the California Department of Health Services. All four reports were presented by the Multi-Ethnic Steering Committee for Health Promotion to the California Department of Health Services in May 1992 in Sacramento, California.

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For more information on any of the Multi-Ethnic Health Promotion Task Force
Reports, please contact the California Department of Health Services
Health Promotion Section, PO Box 942732, Sacramento, CA 94234-7320
916/322-6851

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Forward

As a result of the astounding scientific and medical achievements of the 20th century, we now know that a fuller measure of health is within reach for all Californians. Yet, despite the overall achievements in health status, the burden of poor health all too often falls more heavily on some population groups than on others. The fact that this “gap” in health status occurs more frequently among people with low income and people belonging to racial/ethnic “minority” groups has been documented both nationally and in California. These groups are identified as African American, American Indian, Asian and Pacific Islander, and Hispanic/Latino. Rather than use the term “minority”, the Steering Committee decided that the term “multi-ethnic” was more appropriate given the growth of these populations in California. Not only does this gap in the health status experienced by these racial/ethnic groups include consistently higher excess mortality and poorer overall health as measured by infant mortality rates and disability levels, it also involves disparities in health-related information and resources as well.

Confronting the gap in health status among the State’s multi-ethnic groups began with a vision, followed by action, on the part of Lela Folkers, Barbara Marquez, Virginia Leung Jang, and other key staff of the California Department of Health Services’ Health Promotion Section, which sponsored and coordinated the first Multi-Ethnic Health Promotion Conference in June 1991. As an integral part of that conference, four Ethnic Task Forces, under the leadership of Steering Committee members, were formed to identify critical areas of need with regard to health promotion within their respective communities and then worked one step further to develop health promotion objectives and recommendations for each area. This information was then assembled in the form of a series of discussion papers, which together served as the centerpiece of the conference’s activities.

In addition to the information contained in the original discussion papers, the enclosed Ethnic Task Force Report now incorporates a wealth of additional information garnered from hundreds of conference participants and reviewers. The Task Force Report is prefaced by a summary and background which provides a description of the model used for the development of the ethnic-specific health promotion objectives, a summary of major recommendations, and a discussion of future directions and uses of the information.

The challenge of ensuring good health for all residents is of critical importance in California because our state is home to a large share of the nation’s total racial/ethnic populations. It is projected to be the first mainland state with a majority of “minorities,” an emerging majority if you will, possibly as early as the year 2005. California, as nowhere else in the United States, is a microcosm of multi-cultural living. Strategies to improve health must be based on the fullest possible knowledge of the influences on health and illness for a particular population group. But more often than not, strategies to improve the health of racial/ethnic groups are transplanted or adapted from interventions and research based on middle-income whites. Unfortunately, differences in culture, race, and language are all too often treated as a series of obstacles which must be overcome in providing health care services.

As a member of California's emerging majority, and on behalf of the Multi-Ethnic Health Promotion Conference Steering Committee and its four Ethnic Task Forces, we present the enclosed summary and information on ethnic-specific health promotion objectives and implementation strategies for the year 2000 for California. This report acknowledges the growing recognition by California's multi-ethnic communities of the importance of prevention and early detection of the major causes of excess mortality, illness, and disabilities rather than treatment of a disease after it has occurred. They also emphasize the overwhelming importance of cultural diversity as a guiding principle in the development of health promotion policies and practices.

As the product of one of the largest such undertakings ever brought to fruition in the United States, the Task Force Reports represent the product of many months of work by concerned individuals, health care providers, and educators from public health, academia, and most importantly, from the State's ethnic communities themselves. On behalf of all of us associated with the conference, I wish to take this opportunity to thank each Task Force member and conference participant for his/her contribution to this important effort. Continued cooperation and commitment from such groups and individuals across California will be needed if we are to move our multi-ethnic health promotion agenda forward.

Reaching the goal of equitable health status for all racial/ethnic groups will be one of the most important public health achievements of our time, not just for California, but for many other states as well. Good health and well-being is the greatest legacy we can leave our children and future generations. What we do now will influence the future for good or for bad. Therefore, I invite each of you to join in adapting and using the enclosed objectives and recommendations in your community.

Henry Montes, Chair
Steering Committee
Multi-Ethnic Health Promotion Conference

Acknowledgments

The development of each Task Force Report involved literally hundreds of individuals and organizations. These reports would not have been possible without their commitment and many hours of volunteer work. A special thanks also to the major sponsors of the Multi-Ethnic Health Promotion Conference:

- The California Department of Health Services' Health Promotion Section
- U.S. Public Health Service's Centers for Disease Control (U58/CCU900590-07)
- The California Department Health Services' Tobacco Control Section
- Federal Indian Health Services, California Area Office

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Steering Committee

Multi-Ethnic Health Promotion Conference

Henry Montes, Chair

Henry J. Kaiser Family Foundation

Garth Collins

San Francisco Department of Public Health

Martha Diaz

Hispanic Women's Health Association

George Flores, MD

Sonoma County Department of Public Health

James Forde

California Black Health Network

Felicia Hodge, DrPH

American Indian Graduate Program, University of California, Berkeley

Mingyew Leung

Asian American Health Forum, Inc.

Lia Margolis

Los Angeles County Department of Health Services

Debra Oto-Kent

Health Education Council

Nampet Panichpant-M

Orange County Health Department

John Walmsley

U.S. Public Health Service, Region IX

David Whitehorse

American Indian Program, San Diego State University

Arica Williams

Indian Health Services, U.S. Public Health Service

Elaine Gaines Williams, PhD

Charles Drew University of Medicine and Sciences

Judy Makimoto Woo

Asian Health Services

Lela F. Folkers, Chief

Barbara Marquez, Coordinator

Virginia Leung Jang

Health Promotion Section, California Department of Health Services

Summary and Background

Summary and Background for Advancing a Multi-Ethnic Health Promotion Agenda for California

The Multi-Ethnic Health Promotion Planning Model

Preliminary Planning Efforts

To better address the prevention and health promotion needs of the state's growing multi-ethnic groups, in 1987 the California Department of Health Services' (CDHS) Health Promotion Section coordinated and participated in a two-day workshop in Los Angeles. The purpose of the workshop was to identify emerging and critical issues germane to the state's ethnic groups. Participation was by invitation and the workgroups were largely comprised of representatives from the state's public health and social service organizations, voluntary health agencies, and academic institutions. Three major conclusions emerged from that workshop:

- There is a large unmet need for culturally appropriate and relevant health promotion and risk reduction services targeted toward the state's racial and ethnic population groups.
- There is a wealth of innovative community-based programs being undertaken throughout the state which have proven successful and which might serve as program models for other ethnic communities.
- There is currently no forum or structure for ongoing information exchange of innovations, successful strategies, and program models specifically for health promotion among multi-ethnic groups.

There were strong indications from workshop participants that the planning and direction for future "minority" health promotion efforts will be most successful if they originate from the racial and ethnic community. Since advocacy and information exchange were needed, the CDHS would play a critical role by: 1) directing funding and technical assistance to minority communities; 2) continuing to act as central focal point for data and technology transfer; and 3) creating forums for information exchange by the state's racial and ethnic minority groups. Since that time, the CDHS' Health Promotion Section incorporated most of the recommendations from the 1987 workshop into its state and local assistance programming. The consensus building model used for planning the first Multi-Ethnic Health Promotion Conference held in Sacramento in June 1991 represents one such collaborative effort on the part of many organizations, agencies, groups, and individuals to create the opportunity for communities to advance a multi-cultural health promotion agenda for California.

Planning Process

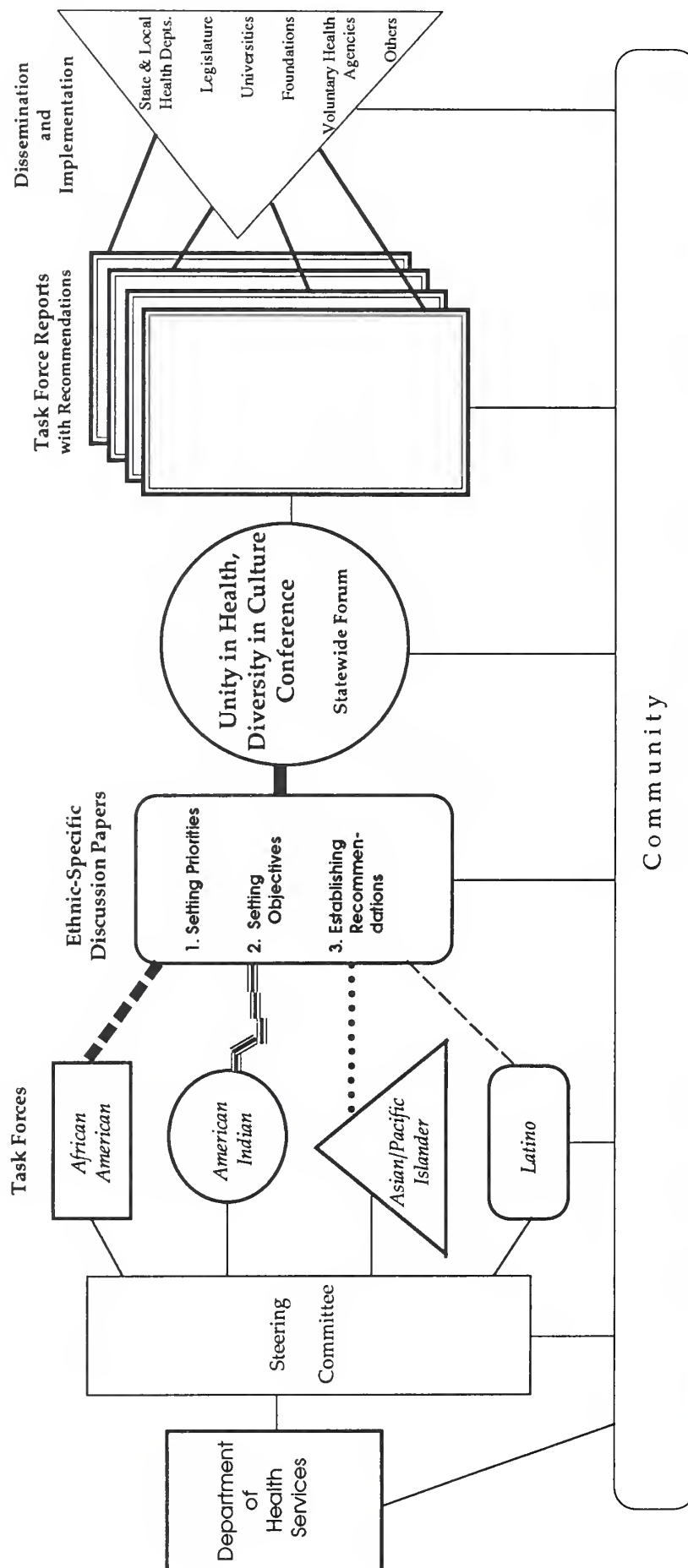
As depicted in Figure 1, “Model for the Development of California Ethnic-Specific Year 2000 Health Promotion/Disease Prevention Objectives,” the Multi-Ethnic Health Promotion Conference was part of a larger planning and consensus-building process. The major elements of the model included the CDHS, a steering committee, four ethnic task force groups, and the community. Working together towards the common goal of creating a multi-ethnic agenda, the task force groups took the lead in (1) identifying health promotion priorities for their respective communities; (2) setting objectives; and (3) developing recommendations for strategies to be pursued to improve health promotion for the state’s ethnic groups.

The methods employed by the task force groups to gain community involvement and to develop the initial discussion papers included: identifying key individuals and groups involved in service delivery, research, training or who otherwise have health promotion knowledge and experience; conducting community assessments through surveys or interviews; and reviewing existing data and key pieces of literature. Once the priority areas were selected and the discussion papers were developed, they were circulated for review and then presented during the conference. Finally, feedback from conference participants concerning priorities, objectives, and recommendations was consolidated into the final task force reports, which together serve as a framework for advancing a multi-ethnic health promotion agenda in California. As shown by the model, community involvement was a key ingredient at each juncture in the development of health promotion objectives, from the initial conceptualization of the project by the CDHS to the dissemination and implementation of the objectives by community groups. This latter activity is described in the “Future Directions” section.

Developing the California Multi-Ethnic Health Promotion Agenda was a one-year consensus-building project that involved a number of resources, key groups, and individuals. The Multi-Ethnic Health Promotion Agenda was conceptualized in response to and as an outcome of earlier planning and program implementation activities of the Health Promotion Section. To ensure that the new health promotion agenda reflected the needs of California’s increasingly diverse population, in November 1990 the CDHS’ Health Promotion Section organized, through internal and external nominations, a steering committee of 15 public health leaders who represented ethnic community-based organizations, academia, and federal and county governments. The steering committee, chaired by Mr. Henry Montes, provided overall guidance for the conference and its members were instrumental in forming and providing leadership for each of the ethnic task forces.

Convened in January 1991, the ethnic task forces were charged with setting health priorities, establishing objectives, and developing recommendations for four key ethnic groups: African Americans, American Indians, Asians and Pacific Islanders, and Latinos. Each group met separately over a six-month period and developed unique working arrangements in accordance with its own infrastructure, resources, and cultural norms. Continuity was provided by the members of the steering committee who provided leadership on the various task forces. The CDHS provided staff support and was able to reimburse the costs of some expenses. However, it should be noted that the majority of the necessary resources were supplied by the steering committee and the task force members on a voluntary basis.

Figure 1
Model for the Development of
California Ethnic-Specific Year 2000
Health Promotion/Disease Prevention Objectives



The resource documents used in the task force deliberations were Healthy People 2000: National Health Promotion and Disease Prevention Objectives, published by the U.S. Department of Health and Human Services¹ and the Summary of Healthy People 2000, prepared by the American Public Health Association². Due to the time constraints inherent in preparing for the June 1991 conference and the fact that the major topic of concern was health promotion and the prevention of chronic disease, the task force groups were asked to limit their deliberations to 10 of the 22 topic areas (see Table 1) listed in these two documents. Within these areas, task force groups were asked:

- To prioritize topic areas and provide a rationale statement concerning the importance, in terms of the health status of the ethnic population.
- To review and comment upon the relevance to the ethnic group of the Year 2000 health status, risk reduction, and service and protection objectives. Each task force was thus able to accept the objectives as written, modify the objectives to make them more relevant, or prepare completely new objectives.
- To make recommendations on three levels -- policy, community interventions, and resource development -- for achieving the objectives.

More than 100 task force members participated in the development of the initial discussion papers. As described more fully in each of the Task Force reports, during the months preceding the conference, each task force employed several activities for prioritizing topics, establishing objectives, and formulating recommendations. For example, some groups formed subcommittees and held regional meetings, while other groups conducted statewide surveys, examined available state and national data bases, and solicited written comments from knowledgeable reviewers.

The Conference Objectives, Process, and Participants

The 1991 Multi-Ethnic Health Promotion Conference played a central role in the development of a multi-ethnic health promotion agenda. It provided a statewide forum to:

- Build public and private partnerships for resource development to expand and enhance health promotion programs and services for multi-ethnic communities.
- Identify and disseminate culturally appropriate and sensitive health promotion and chronic disease programs and models for the African American, American Indian, Asian/Pacific Islander, and Latino communities.
- Create a forum for participants to contribute to the development of a California Multi-Ethnic Health Promotion Agenda based upon the Year 2000 Objectives.
- Explore existing educational and community-based programs and surveillance and data systems and identify gaps in these systems related to multi-ethnic communities and their health status.

In June 1991, the discussion papers were debated at the statewide conference referred to as the Multi-Ethnic Health Promotion Conference, but officially titled “Unity in Health, Diversity in Culture, Advancing a Multi-Ethnic Health Promotion Agenda for California.” Although an attendance of approximately 150 conference participants was initially expected, pre-conference registration had to be closed once the number of participants reached 550 people.

The first day of the conference was reserved for discussion groups on data and surveillance systems, and for seminars on chronic diseases and risk factors, including those related to unintentional injuries and violent and abusive behavior. On the morning of the second day, conference participants were able to attend workshops to learn first hand about successful community interventions, policy strategies, and ways to develop resources. The ethnic-specific breakout sessions were held the remainder of the day. During the breakout sessions, participants had an opportunity to discuss and comment upon the papers they had received earlier as part of the conference materials.

Each breakout session had a facilitator and a recorder. As previously mentioned, community input from conference participants was used to then revise the papers and to draft the final task force reports. The conference steering committee, in conjunction with the task force groups, compiled the final recommendations between June and December of 1991. However, the major changes or new recommendations garnered as part of this working conference were reported to all participants during the plenary session held at the end of the conference. At that time, participants were invited to comment informally (and formally through the written conference evaluation) on the proceedings. There was one final review of the post-conference revised reports by conference participants in August 1991.

Health Promotion Priorities

As stated earlier, in preparing the discussion papers, the task force groups were limited to ten of the twenty-two topic areas in Healthy People 2000. These topics (listed in Table 1) were selected because they fall within the parameters of the Health Promotion and Tobacco Control Sections and their closely allied programs within the CDHS. The Task Force groups selected those areas which members felt to be highly significant to promoting good health within their respective communities. The details of the selection or priority topic areas are shown in Table 1. The rationale for their selection is contained in the individual task force reports. The four groups viewed the areas differently and some of the groups went on to set priority areas while others did not.

Table 1
Priority Health Promotion Topic Areas Selected by each Task Force

	African American	American Indian	Asian/Pacific Islander	Latino
• Physical Activity & Fitness	✓			✓
• Nutrition	✓	✓	✓	✓
• Tobacco	✓		✓	✓
• Violent & Abusive Behavior	✓			✓
• Educational & Community- Based Programs	✓			✓
• Unintentional Injuries				✓
• Heart Disease & Stroke	✓	✓	✓	✓
• Cancer	✓	✓	✓	✓
• Diabetes & Chronic Disabling Conditions	✓	✓	✓	✓
• Surveillance & Data Systems				✓

Source: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. D.H.H.S., 1990. Topic areas in Table 1 are listed in the order in which they appear in Healthy People 2000.

New/Modified Objectives

Once they had identified priority areas for their respective community, each task force was then asked to review the objectives already developed by the Federal Public Health Service and contained in Healthy People 2000. For the most part, the task force groups accepted Healthy People 2000 as a working document which could be adapted to reflect more accurately the most significant needs of specific populations. During the review of existing information, each Task Force could reject, accept as is, or modify the Healthy People 2000 objectives, or develop new objectives for any topic area. Therefore, the objectives listed in each ethnic Task Force Report represent those objectives which, after a review of existing information, were found to be of importance to meet the health promotion needs for that particular ethnic community.

In preparing the early drafts of the discussion papers, several task force and steering committee members had raised the issue that a number of pressing areas of concern, such as HIV infection, alcohol and drug use, maternal and child health issues, immunizations, and infectious diseases, to ethnic communities were not addressed through the chosen process. These limitations were also noted by some conference participants. As discussed in the “Future Directions” section, the activities being planned by task force groups is to use the initial 10 areas as a starting point and to continue planning for the other 12 health promotion and disease prevention objectives which were not addressed in the initial process.

Recommendations for Intervention Strategies

The Process for Developing Recommendations for Intervention Strategies

A major portion of the Multi-Ethnic Health Promotion Conference was devoted to identifying activities and developing strategies for accomplishing the health promotion objectives. The task force groups had completed their prioritization of topics and had reviewed and quantified ethnic-specific objectives through the various processes described above. The conference participants, who were predominantly community representatives, were asked to review and comment on the work of the task forces. After a review of this information, conference workshop participants were asked to develop three levels of recommendations for each topic area. These levels were:

- Policy
- Resource Development
- Community Intervention

Participants were encouraged by the facilitators of each workshop to gear their recommendations to those activities which can make the greatest improvements in health and which will assist the public, health professionals, and decision makers in both public and private sectors in adopting an agenda for advancing multi-ethnic health promotion.

Overall Recommendations

The following recommendations were developed through several methodologies (e.g., community surveys, literature review, interviews, and the iterative group processes used by facilitators and moderators at the conference). These methods culminated in an extensive listing of recommendations and activities for future action, which were compiled and reviewed separately by each of the four Ethnic Task Force Groups.

The following recommendations are presented from the broadest level of intervention at the policy level to the most focused level of implementation at the community level and represent a distillation of those issues and concepts which cut across diverse program areas and interests. They were formulated in response to the following general perceptions:

- Although there is an overall gap in health status between whites and non-whites in California, a wide range of differences exist across ethnic population subgroups.
- The use of averaged white health data as the normative standard or optimal reference point may not necessarily adequately reflect needs for many ethnic populations:
- Health promotion programs for multi-ethnic populations are characterized by insufficient ongoing funding and inadequate manpower resources at all levels (research, training, community intervention). This, in turn, often results in fragmented services and program activities which cannot comprehensively address individual personal health needs nor adequately address the important social/economic/community antecedents to poor health.
- There is a need for effective culturally and linguistically appropriate health promotion educational materials and methods, as well as trained staff.

Recommendations which target discrete agencies or entities appear within each of the individual Ethnic Task Force Reports. However, overall, the recommendations were made with an understanding that no one agency can or should be responsible for addressing the plethora of health promotion issues brought to light by the task force members and conference participants. Rather, at each level of recommendations being offered, a multitude of agencies will need to be actively involved and partnerships formed to achieve results.

An overriding recommendation made by each Task Force on the final day of the conference was to continue the work of the Steering Committee and the conference. Repeatedly, it was recommended that the conference become an annual event.

Summary of Major Policy Recommendations

1. An Office of Minority Health Affairs should be created within State government, either within the Health and Welfare Agency or the Department of Health Services, to: act as or coordinate the activities of an existing agency acting as a central clearinghouse for health-related information and interventions specific to California's multi-cultural communities; coordinate the activities of multiple state programs; provide technical assistance to communities on program planning, implementation, and evaluation; monitor the progress of State agencies and programs whose activities have an impact on the health of California's ethnic populations; and advocate for necessary resources to address emerging problems.

2. State and federal agencies which routinely collect data or which fund programs which collect data should require the use of ethnic-specific identifying information. Where appropriate, these agencies should make a concerted effort to collect the following:
 - Multiple types of information for specific ethnic subgroups, including non-health information which can contribute to the development of health models for ethnic subgroups.
 - Descriptive epidemiologic data to better understand how and when disease occurs among ethnic groups.
 - Anecdotal information from health and service practitioners on interventions and approaches that are effective.
3. All agencies, organizations, and groups concerned with health promotion and disease prevention should advocate for the creation of a legislative multi-ethnic health promotion agenda in California. This advocacy should emphasize the growing importance of prevention and its integration with other services and such integration should take place at the community, regional, and statewide levels.
4. Health promotion should be emphasized in all programs/program areas funded or implemented by the California Department of Health Services and the California Department of Education. The importance of health promotion should be stressed for all participants in entitlement programs administered by the California Department of Social Services, the California Department of Health Services, and the California Department of Mental Health.

Summary of Major Resource Development Recommendations

1. Institutions of higher education in the health sciences should initiate mandatory cross-cultural, bilingual education and training programs for health and social service providers to increase the number of providers who are able to provide high-quality, appropriate multi-cultural services.
2. All educational institutions and voluntary health agencies in California involved in health professional, patient education, public awareness, and public school education should be encouraged to develop and implement culturally appropriate and relevant health promotion, health protection, and disease prevention curricula, and to implement and promote such education and training programs within their jurisdictions.

3. The California Department of Health Services and local health jurisdictions should actively provide technical assistance to community organizations serving ethnic populations on the availability of funding, grant writing, and community organization/mobilization, effective state-of-the-art education and outreach programs for ethnic populations, and the institutionalization of prevention activities in other existing services.
4. Public-private partnerships should be forged between providers of education and medical services to fund pilot programs which increase access to high-quality, comprehensive chronic disease prevention programs for high-risk ethnic populations.
5. Coverage for health promotion and preventive health services should be increased under existing health care financing and social service programs; targeted tax initiatives and tax incentives should be sought to develop stable, long-term funding for ethnic health promotion programs.

Summary of Major Recommendations for Community Intervention

1. Community health promotion interventions should be comprehensive, well-coordinated, accessible, acceptable, and appropriate for the ethnic population(s) they intend to serve. Programs are more likely to be effective if they build upon existing efforts and expertise, use multiple community channels, and involve community constituency groups in all program phases from community assessment and program planning through implementation and evaluation.
2. Community organizations and groups providing or interested in providing health promotion and disease prevention services should create broad-based support through the creation of public-private partnerships and the development of community coalitions.
3. Broad-based community interventions aimed at long-term change in community norms should use a variety of approaches and have multiple targets, such as:
 - individuals (all age/gender groups)
 - organizational (worksites, churches, schools)
 - environmental (local policies and regulations)
 - education (all levels)
 - community organization (coalitions, consortia)
 - regulatory (federal, state, local)
4. Multi-ethnic health promotion is jeopardized by unstable and decreased resources for programs and trained staff. Federal, state, and local health jurisdictions and voluntary agencies should earmark a portion of their resources/activities for multi-ethnic health promotion; those agencies which make grant funding available should earmark a portion of these funds to address the health promotion needs of ethnic groups.

Future Directions

Intent and Distribution of the Task Force Reports

The task force reports provide a framework for efforts to improve health of a large and growing segment of the California population over the present decade. They are intended to serve as a tool for decision makers in public and private agencies in planning and implementing programs. To that end, the conference steering committee has developed a plan for the dissemination of the task force reports. Each conference participant and task force member will receive a copy of each report. The task force groups have developed listings of agencies and individuals who will also receive the Task Force Reports.

To make these reports true working documents, the steering committee has created a list of high and low intensity organizations. The low intensity organizations (e.g., minority organizations, community clinics, community-based organizations) will receive the full set of reports along with the summary information. In addition to this information, the organizations identified as high intensity (e.g., the major voluntary health organizations in California, foundations, hospitals, and health maintenance organizations, professional groups) will receive follow-up contact and technical assistance.

Building Momentum

As a result of the planning process used in the development of the Task Force Reports, hundreds of community organizations, groups, and individuals have now become familiar with Healthy People 2000 and its objectives for health promotion and disease prevention. Healthy People 2000, along with the Task Force Reports, have become important, highly visible working documents.

To continue the forward momentum, the African American Task Force has already distributed a working paper version of its report and in September and October of 1991 initiated training to its members on ways to present the report and how to provide technical assistance on its use. The conference steering committee, which itself is evolving into an ad hoc advisory body and advocacy group, is reviewing this training format and design for possible use by the other task force groups. As part of its new role and in recognition of the importance of ethnic-specific information in policy formation, the chair and members of the steering committee wrote letters of support for the CDHS' application to the Robert Wood Foundation to fund an "Information and State Health Policy Program" which at the time of this writing is being considered for funding.

The task force recommendations are now being actively used by programs within the CDHS, academic institutions, and legislative bodies. The CDHS' Health Education-Risk Reduction Program used the task force recommendations in setting priorities for local funding in its Fiscal Year 1992-93 Request for Applications, issued in November 1991. The CDHS' Special Projects Section used information from the initial discussion papers in the development of its funding

proposal to the Centers for Disease Control for a statewide breast and cervical cancer control program for low-income women. This program was funded in July 1991 and is now in operation. The new Breast and Cervical Cancer Program, in turn, initiated a local assistance funding program incorporating many recommendations. The CDHS' Preventive Medical Services' Target Population Committee is currently using the task force reports in the identification of priority areas and strategies for its chronic disease and injury control activities. The CDHS' Tobacco Control Section, which is responsible for implementing Proposition 99, the Tobacco Tax Initiative, has formed four ethnic networks. These networks are also using the recommendations in their planning of future tobacco prevention and cessation programs.

The planning model and the recommendations are also being used to pattern other similar efforts. For example, in November 1991, the Riverside Health Department presented a series of in-service training sessions for its medical and health education staff modelled after the Multi-Ethnic Health Promotion Conference. The California State University at San Francisco has received a health education grant award and in April of 1992 is presenting a "Multi-Cultural Health Challenges" Career Opportunities Workshop. The Steering Committee members, Task Force leadership, and CDHS staff have been invited to participate. It is also the intent of the Steering Committee to advocate that the planning model be utilized by the Department of Health Services in addressing the other twelve health promotion topics of Healthy People 2000 not addressed at the Unity in Health, Diversity in Culture Conference.

Several exciting activities are also happening on the legislative front. On September 27, 1991, Senators Diane Watson, Art Torres, and Lieutenant Governor Leo McCarthy held a forum on Asian/Pacific Islander Health Issues during which the recommendations from the reports were shared. Information and recommendations from the African American Task Force Report were used at the October 11, 1991 meeting of the California Legislature's Subcommittee on Minority Health Affairs, chaired by Assemblyman Curtis Tucker, Jr.

Later that same month, a Steering Committee member, George Flores, M.D., presented information and an overview of lessons learned from the planning process to the California Conference of Local Health Officers at their October 31, 1991 meeting. Finally, information from the reports were presented at a senate hearing on Youth, Health, and Fitness convened on December 2, 1991 by Senator Charles Calderon at California Polytechnic State University in Pomona.

References

1. U.S. Department of Health and Human Services: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. Government Printing Office, Washington DC., September 1990.
2. Professional Affairs Division, American Public Health Association: Summary of Healthy People 2000: National Health Promotion and Disease Prevention Objectives. (Abridged) American Public Health Association, Washington DC.

**Year 2000
Health Promotion Objectives
and
Recommendations for
Latinos
in California**

Year 2000 Health Promotion Objectives and Recommendations for Latinos in California

Summary on the Preparation of the Latino Task Force Report

The Latino Task Force of the Multi-Ethnic Health Promotion Conference has formulated Year 2000 health promotion objectives and recommendations for policy, community intervention, and resource development for ten topic areas of interest to the Latino community in California. While the body of knowledge concerning health and risk factor status is incomplete for Latinos in many areas, the available data indicate that Latinos experience higher mortality from diabetes mellitus, cancers in certain sites, alcohol-related illnesses, and injuries. Latinos also have relatively high prevalence of many risk factors for chronic disease. These two conditions -- higher rates of disease and high prevalence of risk factors -- in combination with low levels of health knowledge and low utilization of preventive measures, place Latinos at especially high risk for advanced disease.

To begin addressing the health promotion needs of Latinos, the Task Force developed objectives and recommendations in the following areas: Heart Disease and Stroke; Cancer; Diabetes & Chronic Disabling Conditions; Nutrition; Physical Activity and Fitness; Tobacco use; Violent and Abusive Behaviors; Unintentional Injuries; Educational and Community-Based Programs; and Surveillance and Data Systems. The intent of the report and its subsequent discussion of Latino health care and health promotion needs is to generate thought, debate, and action within the community. Hopefully, the report will serve as a catalyst for policy makers, agencies and organizations, and individuals to develop effective strategies which meet the medical and preventive health needs of California's more than seven million Latino men, women, and children.

Introduction

Today, California's Latino population of 7.7 million is the largest of any state in the nation. In fact, California's Latino population in 1990 surpassed the national Hispanic growth rate of 53 percent and had grown by 3.1 million people (a 69 percent increase) in the ten years since the 1980 Census.

Clearly, Latino culture continues to be an integral part of California's diversity. Unfortunately, a legacy of societal apathy toward the economic, political, and social conditions of Latinos has led to many of the critical conditions prevalent today, such as low levels of educational attainment and limited or inequitable access to needed health care services. For the nearly 8 million

Mexican, Cuban, Puerto Rican, Central and South American, and other California Latinos, health status is a major factor which determines their ability to fully participate in and contribute to the State's society and economy. The health needs of the California Latino residents will need to be comprehensively addressed by state and local policy makers, not only to ensure the health and well-being of a large segment of the State's population, but also to foster the economic prosperity of California in the 21st Century.

The Planning Process

As part of a statewide effort to develop an agenda for discussion at the first Multi-Ethnic Health Promotion Conference, the Latino Task Force was charged with reviewing ten preselected health promotion and disease reduction topic areas from Healthy People 2000 and then with developing ethnic-specific Year 2000 objectives and recommendations. To carry out this work in an efficient, yet participatory manner, two work groups were formed -- one representing the northern part of the state and the second representing the southern part. Each group held a series of regional meetings. During the course of their deliberations, a broad spectrum of individuals and concerns were tapped, including members from academia, the media, grassroots organizations, direct service providers, and health care providers from urban and rural areas.

The Southern California group used the Basic Priority Rating System¹ developed by the federal Centers for Disease Control (CDC) and the Southern California group used a modified Delphi method to set the priorities among the ten pre-selected health promotion areas. In both instances, a participatory structured process was employed to enhance the groups' ability to think collectively about the complex issues at hand. Although both groups reached similar conclusions, the differences between the groups were resolved by acknowledging that all ten topic areas held relevance in improving Latino health status.

The two groups then worked jointly in identifying objectives, drafting recommendations regarding implementation strategies, and developing the discussion papers for presentation at the conference. These papers were then debated and refined at the statewide conference. It should be stressed that the process, in its entirety, made every effort to solicit community input and create ownership on the part of all parties involved.

It should also be noted that the work of the Latino Task Force has continued beyond the conference to finalize the report and to plan for its dissemination. In addition to the report itself, one of the most important outcomes of the process has been the development of a network of individuals who are implementing the contents of the report and working toward advancing the Latino health promotion agenda in California.

The following report is, therefore, intended to encourage discussion among concerned policy makers about Latino health promotion and primary care needs. The objectives and recommendations outlined herein can provide a conceptual framework for health policy and the development of additional health promotion strategies which emphasize the differences among Latino subgroups and between other racial and ethnic groups in California.

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Principal Authors of the Latino Task Force Report

The initial drafts of the Latino Task Force Report were completed by Lia Margolis, Mario Reyes, and Harold Goldstein of the Los Angeles County Department of Health Services. The subsequent drafts were authored by the following individuals:

- Physical Activity and Fitness -- *Lia Margolis*
- Nutrition -- *Bea Barraza Roppe*
- Tobacco -- *Bea Barraza Roppe*
- Violent and Abusive Behavior -- *Dan Perales, DrPH*
- Educational and Community-Based Programs -- *Rina Alcalay, PhD*
- Unintentional Injuries -- *Dan Perales, DrPH*
- Heart Disease and Stroke -- *George Flores, MD*
- Cancer -- *George Flores, MD*
- Diabetes and Other Chronic Disabling Conditions -- *George Flores, MD*
- Surveillance and Data Systems -- *Robert Valdez, PhD*

Latino Task Force

Lia Margolis*, Chair, Latino Task Force, Public Health Programs and Services Planning Division, Los Angeles County Department of Health Services

Henry Montes*, Northern California Workgroup Convener, Henry J. Kaiser Family Foundation, Menlo Park

Sylvia Aguirre, Health Officers Association of California, Sacramento

Rina Alcalay, PhD, University of California, Davis

Hugo Almeida, Long Beach Comprehensive Health Center

Delia Alvarez, Santa Clara County Department of Health,

Anna Arguello, Project Bienestar, Hacienda

Yolanda Baldovinos, Alameda County Department of Health

Stanley Bassin, EdD, California State PolyTechnic, Department of Health and Physical Education, Pomona

Minerva Campos, MD, Long Beach Comprehensive Health Center

Ruben Chavez, Santa Cruz County Health Services Agency

Consuelo Diaz, LAC-University of Southern California Medical Center Women's Hospital

Martha Diaz*, Latino Women's Health Association, Sacramento

Bertha Felix, Madera Family Health Center

George Flores, MD, MPH*, Sonoma County Department of Public Health

Aurora Garcia, Livingston Community Clinic, Livingston

Barbara Garcia, Salud Para La Gente, Watsonville

Manuel Garcia, Alliance Medical Center, Healdsburg

Esperanza Garcia-Walters, RN, MPH, Health Education and Training Center, San Jose

Harold Goldstein, Los Angeles County Department of Health Services

David Hayes-Bautista, PhD, Chicano Studies Research Center, University of California at Los Angeles

Crystal Hayling, Self-Help Center, University of California at Los Angeles

Valeria Hernandez, California Children's Services, Covina

Elisa Hill, MPH, Riverside County Department of Health Services

Jose Marquez, Inland Counties Health Services Agency, Riverside

Abel Martinez, Los Angeles County Department of Health Services

Luis Mata, Multi-Cultural Area Health Education Center, Los Angeles

Angie Medina, Los Angeles County Department of Health Services

Hugo Morales, Radio Bilingue, Fresno

Carmen Nevarez, MD, City of Berkeley Department of Health and Human Services

Gilbert Ojeda, University of California, Office of the President, Oakland

Wanda Jean Rainbolt, California State PolyTechnic, Department of Health and Physical Education, Pomona

Steve Ramirez, Fresno County Department of Health

Irene Reveles-Chase, Tobacco Control Section, California Department of Health Services, Sacramento

Mario Reyes, Los Angeles County Department of Health Services

Isabel Ruiz, Nipomo Medical Clinic

Lupe Samaniego, Logan Heights Family Health Center, San Diego

Salvador Sandoval, MD, Merced Family Health Center

Olga Sarabia, Medical Social Work Division, LAC-USC Medical Center, Los Angeles

Nancy Shemick, MPA, Dues Subsidy Program, Kaiser Foundation Health Plan, Inc., Oakland

Janine Souffront, AltaMed Health Services Co., Los Angeles

Lisa Thompson-Dolorier, La Clinica de la Raza Health Project, Oakland

Angie Valencia, Vista Community Clinic

Anne Wheelis, Monterey County Health Department, Salinas

Toni Yaffe, Los Angeles County Department of Health Services

Staff Support: **Barbara Marquez, MPH**, **Nancy Gelbard, RD, MS**, California Department of Health Services, Health Promotion Section, Sacramento

* Steering Committee Members

Physical Activity and Fitness

Physical Activity and Fitness

Rationale

Less than 50 years ago, infectious diseases were responsible for the majority of illness, death, and disability in California. Times have changed. Major public health challenges today are more often the result of individual lifestyle and environmental factors. Health experts agree that much of the chronic illness occurring among Latinos described in this report may result from tobacco use, inadequate physical activity and fitness, and improper nutrition. It is known conclusively that appropriate nutrition and adequate physical fitness lower the risk of developing cardiovascular disease, certain cancers, stroke, obesity, and diabetes. Since cardiovascular disease is a cumulative disease, one is at risk his/her entire life. Ideally, a physical fitness program must be pursued throughout one's lifetime.

Although there is a dearth of physical activity and fitness data on Latinos, this population group would appear to require at least the same level, if not more, of health promotion interventions as the general population to improve their health status through physical activity and fitness programs. There is clearly a correlation between the risk factor/disease and lower socioeconomic status which can be attributed to a number of factors including increases in stress, poor nutrition, and limited access to medical facilities and recreation programs, as well as facilities.

The Latino Task Force emphasizes the need for California-specific, age adjusted, physical growth developmental data for Latinos. All health promotion and risk reduction projects are strongly encouraged to address not only the complexities of the Latino culture, but also those inherent strengths of family, community, education, and religious faith.

Health Status Objectives

- 1.2c** Achieve and maintain desirable body weight in Latinos. Reduce overweight to a prevalence of no more than 25 percent among Latinos aged 20 and older.

(Baseline: Mexican American women aged 20 and older; 39 percent [1982-84].)
- New** Improve general well-being of Latinos.
- New** Develop and identify a surveillance system to track weight/obesity status across the lifespan.

Risk Reduction Objectives

- 1.3** Increase physical fitness of Latinos.
- 1.8/1.9** Increase the number of physical activity and fitness programs in schools and communities.

Services and Protection Objectives

- 1.10/8.6** Increase the number of employers with at least a 25 percent Latino workforce who offer worksite wellness/health promotion programs, including injury prevention programs (i.e., back health and repetitive motion). Physical activity programs at the work place should be affordable and available.
- 1.11** Establish an inter-departmental coalition that will increase the availability and accessibility of physical activity and fitness programs in Latino neighborhoods (i.e., sponsored with the community).
- 10.12/10.13** Encourage manufacturers, restaurants, and other personal service industries to offer fitness, back injury prevention, and health and safety programs for employees.

Recommendations:

The objectives described above provide a framework for establishing the following policy, community intervention, and resource development recommendations to address the lifestyle and environmental factors contributing to chronic disease among California's Latino residents. An emphasis on collaboration and cooperation amongst major state agencies, community agencies, and communities to carry out these objectives was recommended.

Policy

- State and local public health agencies need to build and strengthen existing broad-based community coalitions to develop physical fitness and health promotion programs for Latinos.
- Local school districts should be required to provide self-esteem programs for overweight children and teach acceptance of children with different body sizes and types.
- Fitness education programs for Latinos employed in sedentary or physically undemanding trades should be developed; the aerobic costs of heavy labor and especially the expenditure of the farmworker should be evaluated.
- The California Department of Education should enforce current school-based physical education and fitness policies and provide training for elementary school teachers to deliver physical activity programs.

- The California Department of Parks and Recreation and local recreational departments should plan and install recreational facilities in Latino neighborhoods, with local Latino groups having substantial input in facility placement decisions.
- State government agencies should establish appropriate standards for physical health, physical activity, and fitness. These agencies should conduct and publish annual physical health, physical activity, and fitness assessments to assure appropriate policies are being carried out.
- Insurance company incentive programs should be formed to encourage physical fitness programs at the worksite.

Community Intervention

- Behavior-oriented and culturally appropriate nutrition, fitness, and tobacco awareness education programs for Latinos need to be developed and implemented.
- Health departments, voluntary health agencies, schools, and community-based organizations should collaborate to plan, implement, and evaluate culturally and linguistically sensitive awareness programs to effectively market physical fitness and health promotion messages to Latinos.
- Local law enforcement, public health, schools, and recreation departments should collaborate to develop strategies to ensure that playgrounds and recreational facilities are free of drugs and violence.

Resource Development

- Local schools, public health, parks and recreation departments, criminal justice system and concerned public health professionals should develop a cooperative agreement to subsidize private and public recreational facilities so as to increase access by impoverished Latinos to such programs as Boys and Girls Clubs, and YMCAs and YWCAs.
- Local public health, community organizations, and education agencies should increase the number of accessible sites providing culturally sensitive and linguistically appropriate physical fitness programs.
- Local public health departments should provide training and technical assistance to assist local community-based organizations to design physical fitness strategies and programs.
- Materials developed by government authorities should be available in a culturally sensitive format that incorporates Latino values, attitudes and beliefs.

Nutrition

Nutrition

Rationale

Poor nutrition and, in particular, overnutrition leading to obesity, are contributors to poor health among the California Latino population. Overweight is associated with elevated serum cholesterol levels, elevated blood pressure, and noninsulin-dependent diabetes, and is an independent risk factor for coronary heart disease. Overweight is multifactorial in origin, reflecting inherited, environmental, cultural, and socioeconomic conditions. Overweight is particularly prevalent in minority populations, especially among minority women. The Hispanic Health and Nutrition Examination Survey reported a prevalence of overweight of 41.6 percent among Mexican American women studied.¹ Moreover, overweight acquired during childhood or adolescence may persist into adulthood and increase the risk for some chronic diseases later in life. Overweight occurs when too many calories are consumed and too few calories are expended for individual metabolic requirements. A combination of both caloric control and increased physical activity is important in attaining a healthy body weight. The healthy food practices associated with the traditional foods of Latinos need to be encouraged and supported. It has been noted through clinical observations that an increase in obesity and fat intake are associated with more acculturated Latinos. Research findings are beginning to verify this phenomenon. Restaurants, including fast food restaurants, and institutional food service operations at worksites also play a critical role in the dietary intake of the U.S. population. In 1985, 40 percent of all meals were consumed outside the home.

Health Status Objectives

- 2.3** Reduce overweight to a prevalence of no more than 25 percent among Latinos aged 20 and older and no more than 15 percent among adolescents aged 12 and 19.

(Baseline: According to Healthy People 2000, Mexican-American women have a baseline level [1976-80] of 39 percent. Baseline for low-income Hispanic children younger than age 1 is 13 percent and low-income Hispanic children aged 1 is 16 percent [National figures].)

Risk Reduction Objectives

- 2.5** Reduce total fat intake in the diet of Latinos aged 2 years and older to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories, with particular emphasis on milk products.
- 2.6** Increase complex carbohydrate and fiber-containing foods in the diets of adults to 5 or more daily servings for vegetable (including legumes) and fruits, and to 6 or more daily servings for grain products.

(General population baseline: 2 1/2 servings of vegetables and fruits and 3 servings of grain products for women age 19-50 [DiSogra/California Public Health Foundation/American Cancer Society survey].)

- 2.7 Increase by at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight.
- 2.13 Increase to at least 85 percent the proportion of people aged 18 and older who use food labels to make nutritious food selections.

Services and Protection Objectives

- 2.16 Increase to at least 90 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices consistent with the California Daily Food Guide.

Recommendations:

Policy

- State and local public health agencies should build and strengthen existing community coalitions to develop nutrition education and health promotion programs for Latinos.
- Federally funded food and nutrition programs, such as WIC, should provide culturally appropriate foods and provide messages consistent with the California Daily Food Guide.
- Legislation should be enacted to encourage governmental food and nutrition programs to adhere to the California Daily Food Guide recommendations.
- The CDHS, California Department of Education and local school districts and PTAs should advocate for the policies eliminating “junk food” in vending machines on school campuses and substituting instead the sale of nutritionally dense foods.
- Public and private schools should provide self-esteem programs for overweight children.
- Advertisement campaigns targeted at the Latino population in California to consume higher fat milk products should be eliminated.
- State and federal government should enact legislation for labeling fast foods.

Community Intervention

- Incorporate the concept of physical activities and fitness into nutrition education programs across the lifespan.

- Collaborate with health departments, voluntary agencies, schools, and community-based organizations to market and implement effective health promotion and nutrition programs to Latinos that are culturally sensitive and linguistically appropriate.
- Encourage community-based, school-based, and worksite-based health promotion programs that provide nutrition education to encourage healthy food choices.
- Develop, implement, and evaluate strategies to provide nutrition information in grocery stores and restaurants to assist consumers in making healthy food choices.
- Promote the consumption of lower fat milk products; programs need to address Latino beliefs, values and taste preferences regarding milk.
- The CDHS and county health departments should establish a surveillance system to track adolescent and adult obesity and overweight status.
- Support the continuation of the California Pediatric Surveillance System in conjunction with the federal Centers for Disease Control to track childhood obesity, underweight status, and anemia.

Resource Development

- Fund studies to determine appropriate measures to assess healthy/ideal body weight standards for Latinos.
- Increase the number of accessible sites providing culturally sensitive and linguistically appropriate nutrition programs.
- Encourage state and local public health departments to provide training and technical assistance to local community-based organizations in developing nutrition interventions.
- Develop and/or adopt nutrition education materials which are culturally sensitive and linguistically appropriate.
- Establish a statewide nutrition clearinghouse within the jurisdiction of the CDHS, Health Promotion Section.

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Tobacco

Tobacco

Rationale

Epidemiologic studies continue to show that tobacco use exacts a heavy morbidity and mortality toll on the U.S. population. Tobacco consumption is responsible for at least one-quarter (300,000) of all cancer deaths.

The pattern of cigarette use among Latinos in California differs markedly with gender. Male Latinos have rates of current smoking (23.5 percent) that are nearly identical with the rates for non-Latino males (23.9 percent), but rates for Latinas (12.9 percent) were substantially lower than those for non-Latino females (20.3 percent). (CHDS, 1991). Like many other minority and disadvantaged groups, Latinos are at a higher risk for tobacco use because of their lower socioeconomic status (blue-collar workers or unemployed persons, less educated persons). For example, the prevalence of smoking in 1985 was higher among persons without a high school diploma (35.4 percent), whereas it was only 16.5 percent among persons with at least a college education.

Because tobacco use is very addictive, health professionals and policy makers must address the broad implications not only for the tobacco consumers but also for the non-users. In order to reduce the morbidity and mortality associated with tobacco use, the State government must take a more active role in establishing appropriate legislation to: 1) fund research to find the most effective interventions against tobacco use; 2) include under Medicaid the treatment of tobacco addiction, and encourage third-party payors to cover this treatment as they cover treatment for alcohol and drug dependence; and 3) establish/enforce appropriate public policies for how tobacco products are sold and distributed in our society.

Public information campaigns should be developed to increase community awareness of the addictive nature of tobacco use. Any community-based or school-based intervention used to reduce or eliminate tobacco use among Latino youth should include multiple components, including parental involvement, with emphasis on language and cultural dimensions. Local communities will have to establish policies to regulate and enforce the sale of tobacco products to minors and enact policies to reduce or ban tobacco product advertisement in the close proximity of schools.

Health Status Objectives

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|------------|---|
| New | Reduce incidence of cardiovascular disease and cancer in Latinos. |
| New | Reduce the incidence of smoking-related respiratory illness, including asthma, among Latino children. |

Risk Reduction Objectives

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|------------|--|
| 3.4 | Reduce tobacco use to a prevalence of no more than 18 percent among Latinos aged 20 and older.

(Baseline: 33 percent in 1982-84.) |
| 3.5 | Prevent the initiation of all tobacco use by Latino youth through decreasing the available supply of tobacco to youth. |

Services/Protection Objectives

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|------------|--|
| New | Provide education programs for parents about the risks of environmental tobacco smoke to all family members. |
| New | Reduce or eliminate media tobacco advertisements targeting Latinos and counter with culturally appropriate tobacco prevention education programs and awareness campaigns. |
| New | Develop culturally and linguistically appropriate community and school-based health promotion programs in each county (with networking and information sharing built into the design) in order to prevent and eliminate tobacco use among Latinos. |
| New | Increase to 90 percent the number of community and rural clinics, hospitals, HMOs, and large group practices who routinely provide patient and community tobacco prevention and cessation programs. |

Recommendations:

Policy

- Increase State funding for research into health problems in the Latino community that are either caused or exacerbated by tobacco.
- Increase State funding for research to determine effective interventions and prevention strategies to reduce Latino tobacco use.
- Provide Medi-Cal coverage for the treatment of tobacco addiction.
- Require third-party payers to cover the treatment of tobacco addiction in the same way they cover alcohol and drug treatment.
- Enact and enforce zoning laws to control the distribution and operation of new and existing alcohol and tobacco outlets in Latino neighborhoods so as to reduce their proliferation, undue concentration, and placement in high-risk environments.
- Ban all billboards or enact laws to restrict the placement of billboards so that Latino areas are not besieged by a disproportionate number of tobacco billboards.
- Fund programs that set the Latino community health agenda and generate public discussion on tobacco use as a health priority.
- Build and strengthen existing coalition for broad-based community tobacco education and health promotion programs for Latinos.
- Support programs that generate Latino community support for non-smoking policies and non-smoking as a social norm.
- Encourage enforcement and adherence to current laws regarding tobacco sales to minors.
- Raise excise taxes on all tobacco products and designate the revenue for tobacco use prevention projects.

Community Intervention

- Coordinate tobacco prevention and cessation programs at schools, community agencies, medical clinics, and medical practices in order to achieve a comprehensive and thorough approach.
- Develop culturally appropriate and behavior-oriented tobacco awareness education programs for Latinos that reflect the cultural realities of the Latino family and neighborhood.
- Encourage community business advocacy groups to support local voluntary groups in their efforts to refuse financial support from tobacco companies by developing alternative funding sources.
- Encourage the local affiliates of national Latino/Hispanic organizations to make tobacco use prevention a top priority.
- Concentrate health promotion efforts at worksites where Spanish-speaking workers dominant the workforce and in work settings likely to be highly representative of Latino workers.
- Develop a specific arm within the CDHS-funded Tobacco Education Clearinghouse to constructively guide community agencies wishing to develop culturally sensitive and linguistically appropriate programs or educational material for Latinos.
- Support and fund programs which have a community based “in-reach” organizational model which recruits, trains, and retains community health workers who are identified as belonging to the naturally occurring social and kinship linkages existing in the community.

Violent and Abusive Behavior

Violent and Abusive Behavior

Rationale

Latinos, particularly males, like other socially and economically disadvantaged groups, are at greater risk for violence related injuries than the general population. This phenomenon may reflect the interaction of social and environmental factors such as poverty, limited access to quality education, higher than average levels of alcohol use and abuse, and fewer social advancement opportunities. Among newly arrived Latino immigrants, the incidence of injuries may be higher than among U.S.-born Latinos. This disparity may be due to unfamiliarity with local laws, an unwillingness to seek protective measures (e.g., report assaults to police), and difficulties with language.

Following are the Year 2000 objectives for reducing violent behavior among California Latinos:

Health Status Objectives

- 7.1 Reduce homicides among Latino males aged 15 to 34 by 20 percent from 45.0 (California baseline, 1987) to 36.0 per 100,000 people.
- 7.2 Reduce suicide among Latinos by 20 percent from 11.0 (California baseline, 1988) to 8.8 per 100,000 people.
- 7.4 Reduce physical and sexual abuse of children to less than the 1986 U.S. baseline.
(U.S. baseline: [physical] 5.7 per 1,000 in 1986; [sexual] 2.5 per 1,000 in 1986.)
- 7.5 Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples.
(U.S. baseline: 30 per 1,000 in 1985.)
- 7.6 Reduce assault injuries among people aged 12 and older to no more than 10 per 1,000 people.
(U.S. baseline: 11.1 per 1,000 in 1986.)

Risk Reduction Objectives

- 7.9** Reduce by 29 percent the incidence of physical fighting among adolescents aged 14 through 17 (e. g., gang members).

(U. S. baseline data unavailable in 1991.)

- 7.10** Reduce by 20 percent the incidence of weapon-carrying by adolescents aged 14 through 17.

(U.S. baseline data unavailable in 1991.)

Services and Protection Objectives

- 7.12** Expand culturally/linguistic relevant clinical protocols for routinely identifying, treating, and properly referring suicide attempts, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments.

(U.S. baseline data available in 1992.)

- 7.15** Reduce to less than 10 percent the proportion of battered women and their children turned away from emergency housing due to lack of space.

(U.S. baseline: 40 percent in 1987.)

- 7.16** Increase to at least 50 percent the proportion of elementary and secondary schools that teach culturally relevant non-violent conflict resolution skills, preferably as a part of quality school health education.

(U.S. baseline data unavailable in 1991.)

Recommendations:

Policy

- Public health, education, mental health, social services, and criminal justice policy makers should collaborate with the Latino community to design coordinated services that can effectively reduce violent and abusive behavior among Latinos.

Community Intervention

- Programs should be developed for Latinos to reduce violent and abusive behavior.
- Self-help groups for Latinos who manifest violent behavior (e. g., men who batter, child abusers) need to be established.
- Injury experts and health care professionals should collaborate in developing local violence prevention programs and campaigns.
- Parental participation in community violence prevention programs needs to be increased.
- Culturally/linguistically relevant classes for parenting, conflict resolution, communication skills, and non-violent defense needs to be made available.
- Conduct an awareness campaign targeted to Latino women on their legal rights as they pertain to domestic violence.
- The availability of protective resources (e.g., shelters) needs to be promoted among Latino women.

Resource Development

- Resources for school-based and after-school programs that can enhance personal skills, self esteem, and career opportunities for young adult Latinos, (e.g., constructive alternatives to gang activities for idle Latino youth) need to be augmented.
- Funding should be made available to shelters and community organizations that provide services to battered Latino women, abused Latino children, and Latino runaways.

Educational and Community-Based Programs

Educational and Community-Based Programs

Rationale

Although the body of data on Latino health is deficient in many areas, what is known indicates a higher risk for certain diseases, including diabetes, cancer in selected sites, alcohol related illnesses, and HIV infection, as well as a high prevalence of risk factors and unacceptably low levels of knowledge and utilization of preventive measures and services. Health promotion programs and messages targeted to the Latino community need to be culturally sensitive and linguistically appropriate in order to effectively meet the needs of the population. Programs must be developed with input from the target population. There should be greater reliance and utilization of Latino community-based organizations in providing public health education programs and services. Community-based organizations can serve as a vehicle for reaching Latinos with public health education and disease prevention/health promotion activities and information.

Further, if we are to ensure California's economic prosperity as we enter the 21st Century, all residents must be able to fully participate in its political, economic, and social processes. Greater focus needs to be directed to underserved subgroups of Latinos, especially migrant workers, newly arrived immigrants, one-day workers, and adolescents. We can begin by improving the health and increasing high school completion rates among Latino youth. However, because of poor health, unequal educational opportunities, poverty, low performance expectations on the part of schools and the students themselves, and lack of parental involvement, high school drop out rates among Latinos in California are as low as 50 to 60 percent.

Health Status Objectives

8.1b Increase years of healthy life for Latinos to at least 65 years.

(Baseline: an estimated 62 years in 1980.)

Note: Years of healthy life (also referred to as quality-adjusted life years) is defined as the average duration or quantity of life discounted by an estimate of the quality of life. It is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure should also be tracked.

Risk Reduction Objectives

- 8.2** Increase the high school graduation rate of Latinos to at least 75 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. The objectives from Healthy People 2000 mention 90 percent as a goal. But given the current low rate of high school graduation for Latinos (50-60 percent), the 75 percent graduation rate seemed to be a more realistic goal.

Note: High school dropouts are people aged 16 through 24 who are not enrolled in school and are not high school graduates. People who have received high school equivalency credentials are counted as graduates.

Services and Protection Objectives

- 8.3** Achieve for all Latino children access to high-quality, culturally/linguistically sensitive and developmentally appropriate preschool programs, (i.e., Head Start Programs) that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health.

- 8.4** Increase to at least 75 percent the proportion of the State's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education.

(Baseline data unavailable in 1991.)

- 8.6** Increase to at least 85 percent the proportion of workplaces with 50 or more employees that offer health promotion activities for their employees and place special emphasis on job environmental health education so employees can make more informed choices about hazardous tasks.

- 8.11** Increase to at least 50 percent the proportion of counties where a racial/ethnic minority group constitutes more than 10 percent of the population that have established culturally and linguistically appropriate community health promotion programs for these populations.

(Baseline data available in 1992.)

- New** Establish a clearinghouse of materials and programs targeted to the Latino community, which will also serve as a source of technical assistance and training.

Recommendations:

Policy

- Encourage educational institutions and community-based programs to increase Latino representation as advisors and policy makers in their organization.
- Encourage and facilitate involvement of Latinos in the political process at the local (i.e., school boards, community task forces), regional, state, and national levels.
- Encourage private industry and public agencies to take an active role in the educational development of Latinos through mentoring, work study programs, and recruitment efforts.
- Provide adequate level of funding for educational programs targeted to California's Latino residents, from preschool to college.
- Establish and implement mandated culturally relevant health education in the K-12 grade levels.
- Increase research on behavioral change and social marketing in the Latino community.

Community Intervention

- Develop effective health promotion programs and campaigns that are culturally sensitive, focus on the positive cultural attributes of the community, and increase the community's awareness about risk factors and reduction measures (i.e., use of preventive health services). This excludes the simple translation of materials/programs developed in English for non-Latinos.
- Increase academic attainment and health education awareness among Latinos in a culturally and linguistically sensitive manner for the issues addressed in this report.
- Encourage Latino youngsters to stay in school by developing programs that increase career options/aspirations through experience-related courses, mentoring programs and/or incentive programs.
- Provide training and technical assistance to local coalitions, employers, and others wishing to design effective health education programs.
- Design interventions with a comprehensive health care perspective (psycho-social, nutrition, health education) for the total individual and whole families.

- Emphasize the dissemination/diffusion of existing health information/materials/programs through the media, community networks, and a variety of culturally appropriate communication channels, which may include non-traditional sites for health education (i.e., theater, English as a Second Language classes).
- Empower the Latino community to access resources, conduct advocacy and political actions, and apply economic incentives to change their environment.
- Utilize “comadres,” grandparents, and other extended family members as communication channels for providing health education.
- Develop education programs targeting Latino parents as it relates to retention of students.
- Increase the amount of non-traditional health education methodology and programs (i.e., conflict resolution, self-esteem, communication skills) being targeted toward the Latino community.
- Increase patronization of companies which support ethnic communities and boycott those which are not cooperative.
- Eliminate system barriers that discourage Latinos from adequate access to care (i.e., long waiting time, lack of bilingual staff).

Resource Development

- Funding from public and private sources for educational and community-based health promotion programs targeting Latinos should be substantially increased.
- Funding for community events by tobacco and alcohol companies should be phased out and alternative sponsors for these events should be identified.
- Increase the pool of bilingual and bicultural staff who are sensitive to the needs of Latinos.
- Train health professionals in the delivery of culturally appropriate disease prevention and health promotion programs and services.
- Provide third-party reimbursement for health education services provided by health educators and other healthcare providers.
- Train and recruit bilingual/bicultural teachers to serve as role models.
- Establish Child Health and Disease Prevention (CHDP) screening programs at schools.
- Decrease the State-mandated ratio of students per nurse. Designate school nurses as the “case managers” for the psycho-social, nutrition, and health education needs of students. Increase the percentage of Latino school nurses.

Unintentional Injuries

Unintentional Injuries

Rationale

Unintentional injuries are not accidents. They are not random events that occur at the whim of some unseen force. Unintentional injuries occur according to a logical sequence of events and thus, are potentially preventable. The prevention of death and disability resulting from such injuries requires multidisciplinary approaches that involve educational, environmental, and policy interventions. General approaches to prevention, as noted in the National Research Council/Institute of Medicine Report, Injury in America, include:

- *Persuade* persons at risk of injury to change their behavior for increased self-protection (e.g., urge the use of seat belts or teach anger reduction techniques).
- *Require* behavior change by law or regulation (e. g., laws requiring seat belt use or smoke alarms in hotels).
- *Passive or automatic protection* by changes in environment (e.g., sprinkler systems to extinguish fires automatically) or equipment design (e.g., install auto air bag).

Each approach to injury prevention provides some measure of protection. However, among injury prevention and control experts, it is generally recognized that changing behavior by laws or regulations is more effective than persuasion and that automatic protection is the most effective approach. Prevention efforts should recognize the role that alcohol and drugs play in injury.

Injuries are the primary cause of death among Californians between the ages of 1 and 44. Fatal injuries include injuries from intentional (e.g., homicide) and unintentional (e.g., motor vehicle crashes) causes. Injuries account for only 8 percent of all deaths that occur in California annually. However, unlike cancer and heart disease (which most often occur to persons older than age 45), injuries occur primarily among younger-age persons.

The social impact of injury is often estimated by the years of potential life lost (YPLLs); that is, the number of years a young injury victim would have lived before reaching the age of sixty-five. During 1988 in California, premature death due to intentional and unintentional injuries resulted in 466,000 YPLLs. This amount was more than the total YPLLs of all cancer and heart disease deaths combined (i.e., 334,000).

In 1987, California's Latinos had a birth rate nearly forty percent higher than the statewide rate. Indeed, one in three Latino American children lives in California. The youthfulness of California's Latino population places them at high risk for injury deaths. Fatal injuries are the third leading cause of death among Latinos in California, compared to the fifth leading cause among non-Latino whites.

The objectives described below provide a framework for establishing the policy, community interventions, and resource development recommendations necessary to address factors contributing to intentional and unintentional injuries among California's Latino residents.

Health Status Objectives

- 9.1** Reduce deaths among Latinos caused by unintentional injuries by 20 percent from 32.5 to 26.0 per 100,000 people.¹

(California baseline, 1987.)

- New** Reduce deaths among Latino males caused by unintentional injuries by 20 percent from 57.8 to 46.2 per 100,000 people.²

(California baseline, 1988.)

Risk Reduction Objectives

- 9.12** Increase the use of occupant protection systems, such as safety belts, auto air bags, and child safety seats, to at least 85 percent of motor vehicle occupants.

(U.S. baseline: 42 percent in 1988.)

Services/Protection Objectives

- 9.18** Provide culturally relevant academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 50 percent of public school systems (grades K through 12).

(U.S. baseline data available in 1991.)

Recommendations:

Policy

- Public health, education, mental health, social services, and criminal justice policy makers should collaborate with the Latino community to design coordinated services that can effectively reduce unintentional injuries among Latinos.
- The California Legislature should mandate and provide funding for statewide injury prevention programs in the Latino community modeled after the Proposition 99 tobacco control effort. These funds may be used for communities to establish injury prevention demonstration projects that can be emulated by other California communities.
- The CDHS should provide training and technical assistance to communities to develop injury prevention programs.
- The CDHS should establish a statewide injury surveillance system that will include injury morbidity and mortality data on Latinos.
- The CDHS should conduct epidemiologic studies of injury morbidity and mortality among Latinos.

Community Intervention

- Public awareness of the significance of unintentional injury among Latino subgroups needs to be increased.
- The use of traditional non-alcoholic beverages at social, sporting, and community events should be promoted.
- Injury experts and health care professionals should collaborate in developing local violence prevention programs and campaigns.
- Increased parental participation in community injury prevention programs should be encouraged and supported.
- Business and government should work together to increase and enhance programs to prevent occupational injury to Latinos in farm labor, manufacturing and construction, and service establishments (e.g., restaurants and hotels).
- The promotion of alcoholic beverages in family restaurants, sporting, and community events should be eliminated.

- Effective injury prevention media campaigns need to be developed in collaboration with the media industry.
- The proportion of preschool teachers and daycare providers who routinely provide information and education to children and parents on injury prevention need to be expanded.
- The proportion of primary care providers who routinely provide age appropriate counseling to parents and patients on injury prevention needs to be increased.
- School-based pedestrian and occupant safety education programs for Latino children and their families need to be offered.

Resource Development

- Alcohol treatment programs for Latinos needs to be accessible and available.

References

1. Vital Statistics of California. 1987. California Department of Health Services, July 1989.
2. EPIC Proportions: Fatal Injuries in California. 1988. California Department of Health Services, Emergency Preparedness and Injury Control (EPIC) Program, Sacramento, California.

Heart Disease and Stroke

Heart Disease and Stroke

Rationale

Heart disease and stroke are among the leading causes of death for Latinos, as they are for non-Latino whites (NHW). However, the death rate from cardiovascular diseases appears to be actually lower for Latinos, (52.8/100,000 for Latinos vs. 75.7 for NHW in 1989, as reported by the California Department of Health Services (CDHS). Data from the CDHS' Human Population Laboratory (1983-1987), indicate lower rates of hospitalization of Latinos for heart disease, hypertension, and stroke.

Additional information is needed about California Latino's major risk factors for heart disease and stroke relative to country of birth, generation in California, degree of acculturation and traditional diet. Evidence from the Hispanic Health and Nutrition Examination Survey (HHANES) indicates a greater prevalence of obesity among Latinos and other studies have shown higher levels of cholesterol and triglycerides in Latinos than among NHWs (DHHS, 1986). Latinos who are poor exhibit a higher risk for unrecognized and untreated hypertension. Data regarding tobacco use is rapidly accumulating and indicate that men who are less acculturated have higher smoking rates and women who are more acculturated actually smoke more.

Although aggregate outcome for heart disease and stroke may appear to be more favorable for Latinos, it is well documented that Latinos have generally less access to preventive care, higher levels of insurance, and tend to appear later for care of chronic conditions. Consequently, it may be expected that Latinos suffer disproportionately from otherwise preventable heart disease and stroke, and from their more advanced stages and sequelae.

Health Status Objectives

15.1 Reduce coronary heart disease deaths to no more than 50 per 100,000 for Latinos.

(Age-adjusted baseline: 52.8 per 100,000 in 1989.)

Risk Reduction Objectives

- 15.10c** Reduce overweight to a prevalence of no more than 20 percent among Latino women aged 20 and older, and no more than 15 percent among Latino adolescents aged 12 through 19.

(Baseline: 39 percent for Latinas age 20-74 in 1982-84; 15 percent for adolescents in 1976-80.)

- 15.12e** Reduce cigarette smoking to a prevalence of no more than 18 percent among Latinos age 20 and older.

(Baseline: 33 percent is 1982-84 baseline for Latinos age 20-74.)

Services and Protection Objectives

- 15.13** Increase to at least 90 percent of the proportion of Latino adults who have had their blood pressure measured within the preceding 2 years and can state in English or Spanish, whether their blood pressure was normal or high.

(Baseline: none specific to Latino; 61 percent for total population.)

Recommendations:

Policy

- California's Medi-Cal Program should develop a disease prevention program for adults which features periodic screening and education for prevention or early detection of heart disease cancer, and diabetes, patterned after the CDHS Child Health and Disability Prevention (CHDP) Program.
- A state clearinghouse must be developed for culturally relevant, field-tested material and information on heart disease, cancer, and diabetes.
- Mortality data for California Latinos should be broken down by country of origin and parentage.
- A CDHS Committee on Latino Chronic Disease Prevention must be formed to address and to advise public and private entities on policy, appointments, and programs.
- Public and private third party payers must provide fair reimbursement for health education, preventive health screening, and nutrition education.

- Universal access to preventive health care and health education services must be assured for all people in California, regardless of national origin, citizenship, or employment status.
- The State and federal governments must establish physiologically appropriate anthropomorphic and blood pressure standards for Latinos.
- Heart disease and stroke risk reduction programs effective with Latinos in Texas, Florida, Puerto Rico, Mexico, Costa Rica, etc., should be reviewed for their applicability in California.
- Require all public and private agencies receiving state funds to ensure access to culturally appropriate bilingual education, information, and services for chronic disease prevention and control.
- The CDHS' Office of Family Planning (OFP) and Title X-funded clinics should provide hypertension, cancer, and diabetes screening services for non-contracepting women.
- The University of California Cooperative Extension Program should provide research on and development of low-fat, lower-calorie cooking methods for traditional foods of Mexico/Latin America, and market such methods aggressively to restaurants and consumers.
- Private, non-profit organizations involved in chronic diseases control (e.g., heart disease, cancer, diabetes, lung) should establish research about disease prevention in Latinos as their top priority activity for the 1990s.

Community Intervention

- Local communities must form coalitions between public and private entities to address local services and to collaborate on efforts for prevention of chronic diseases.
- Community service providers and public health agencies should establish community-based, chronic disease screening for heart disease risk factors in familiar stores, churches, restaurants, etc.
- The Federal Food and Drug Administration (FDA) should require that nutrition information on food packaging be provided in both Spanish and English or be in internationally understood symbols.
- The California Department of Education should develop and implement: heart disease prevention curriculum; family-oriented programs to address chronic disease prevention; cafeteria meals and social events exhibiting healthy choice meals; and culturally interesting physical activities adaptable to daily routine.
- Daycare licensure should require basic nutrition education for operators, information for parents, and nutritious meal preparation for children.

- Community service providers and public health agencies should build Spanish-language media contacts and mount campaigns focusing on chronic disease prevention, detection and the need for follow-up.
- Community service providers and public health agencies should focus health education efforts on “Latino-dominant” worksites: farm labor, manufacturing, textiles, and the service industry.
- Community service providers and public health agencies should use English as a Second Language (ESL) classes as vehicle for focused discussion about high blood pressure, smoking, obesity, and diet as risk factors for heart disease, cancer and stroke.
- Community service providers and public health agencies should ensure childcare is provided during didactic sessions on chronic disease prevention and nutrition.

Resource Development

- Tax incentives should be offered to employers to provide/allow access to chronic disease prevention instruction for employees.
- Registration fee discounts and other incentives should be offered to Mexican food vendors and other restaurants to incorporate and promote healthy-choice foods, complete nonsmoking policies, and instruction for chronic disease prevention for employees.
- The University of California Extension Program must also develop and promote culturally attractive dietary guidelines for high cholesterol, high blood pressure and cardiovascular risk and then provide in-community demonstrations using appropriate role models.
- Training, education, hiring and promotion of bilingual/bicultural health providers and educators in California must accelerate to meet the growing needs of the Latino population.
- Training programs for health workers on the special chronic disease prevention needs and strategies of Latinos should be implemented statewide.
- Bilingual/bicultural community health outreach workers should be utilized extensively to screen for chronic diseases and to provide prevention education.
- The Federal Public Health Service (PHS), the CDHS, and private foundations should fund pilot programs for mobile screening of migrants and other populations with difficulty in access to detection, treatment and education of hypertension, smoking, obesity, cholesterol, cancer, and diabetes.

Cancer

Cancer

Rationale

Cancer accounts for about one of every six deaths occurring among Latinos in California. Cancer is diagnosed 25 percent less often in Latinos than in non-Latino whites (NHW) but the average survival following diagnosis is shorter for Latinos (DHHS, 1986). Occurrence of and death from several types of cancers (liver, cervix, stomach, prostate) is greater among Latinos than NHWs.

Occupational exposure to real and potential cancer causing substances, such as asbestos and certain chemicals, used in agriculture and manufacturing is more common for Latino workers than NHWs. Tobacco use is increasing among Latino teenage females. Very low rates of participation in cancer screening [mammography, Papanicolaou (Pap) tests, colon and prostate cancer screening] is a manifestation of underinsured and other barriers to access for many Latinos.

A 1985 American Cancer Society survey indicated that Latinos are relatively unaware of the warning signals of cancer, available diagnostic tests, and ways to reduce cancer risk. A large portion of the 20-25 percent of women in the Hispanic Health and Nutrition Examination Survey (HHANES) study who had never received a Pap test were not born in the United States, had a lower level of education, had a lower income, could not read English, and did not have private medical insurance. Cultural or personal prohibitions regarding self-manipulation of breasts or testicles for cancer detection and myths about cancer causation are not uncommon. Moreover, the California-Mexico border is a “hot spot” for commerce in unproven cancer remedies.

Health Status Objectives

New Reduce incidence of cervical cancer to no more than 7 per 100,000 Latino women.

(Age-adjusted baseline 15.4 per 100,000 in 1988, California Tumor Registry.)

New Reduce deaths from liver cancer to no more than 3 per 100,000 Latino men.

(Age-adjusted baseline 6.1 per 100,000 in 1988, California Tumor Registry.)

Risk Reduction Objectives

16.6e Reduce cigarette smoking to a prevalence of no more than 18 percent among Latinos aged 20 and older.

Services and Protection Objectives

- 16.11a** Increase to at least 80 percent the proportion of Latino women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years.

(Baseline: 54 percent of Latino women age 40 and older ever in 1988-90; 48 percent of Latino women age 50 and older within the preceding 2 years in 1988-90, California Behavioral Risk Factor Surveillance System [BRFSS].)

- 16.12a** Increase to 95 percent the proportion of Latino women aged 18 and older with uterine cervix who have ever received a Pap test and to at least 85 percent those who received a Pap test within the preceding 1 to 3 years.

(Baseline: 75 percent “ever” and 66 percent within the preceding 3 years in 1987.)

Recommendations:

Policy

- The California Medi-Cal Program should develop a disease prevention program for adults which features periodic screening and education for prevention or early detection of heart disease cancer and diabetes, patterned after CHDP.
- A state clearinghouse must be developed for culturally relevant, field-tested material and information on heart disease, cancer, and diabetes.
- Federal, State, and private agencies should be required to define cancer on mortality data for California Latinos and should be broken down by country of origin and parentage.
- A CDHS Committee on Latino Chronic Disease Prevention must be formed to address and to advise public and private entities on policy, appointments, and programs.
- Public and private third party payers must provide fair reimbursement for health education, preventive health screening, and nutrition education.
- Universal access to preventive health care and health education services must be assured for all people in California, regardless of national origin, citizenship, or employment status.
- The California Department of Education should include culturally sensitive cancer prevention education in elementary and secondary school curricula.

- CDHS and/or the University of California should assess cancer risk for Latinos, especially children from environmental and occupational exposure to toxic substances.
- CDHS' Office of Family Planning (OFP) and Title X-funded clinics should provide hypertension, cancer and diabetes screening services for non-contracepting women.
- Require all public and private agencies receiving state funds to ensure access to culturally appropriate bilingual education, information and services for chronic disease prevention and control.
- The U.S.-Mexico Border Health Association should work to eliminate the promotion and sale of unproven cancer remedies along the border.
- The University of California Cooperative Extension Program should provide research on and development of low-fat, lower-calorie cooking methods for traditional foods of Mexico/Latin America and market such methods aggressively to restaurants and consumers.
- Private, non-profit organizations involved in chronic diseases control (e.g., heart disease, cancer, diabetes, lung) should establish research about disease prevention in Latinos as their top priority activity during the decade of the 1990s.

Community Intervention

- Local communities must form coalitions between public and private entities to address local services and to collaborate on efforts for prevention of chronic diseases.
- Bilingual/bicultural cancer survivors and role models who have received periodic screening or participated in education for cancer prevention should be used in community-based cancer prevention programs in schools, churches, health fairs, job-sites, union halls, amnesty offices, cantinas, etc.
- Community service providers and public health agencies should develop culturally sensitive strategies for Latinos to dispel cancer myths, to decrease fear of cancer, and to increase acceptance of body examination for cancer screening.
- Instruction in breast self-exams and testicular self-exams should be mandatory instruction in high school physical education classes.
- Community service providers and public health agencies should build Spanish-language media contacts and mount campaigns focusing on chronic disease prevention, detection and the need for follow-up.

- Community service providers and public health agencies should focus health education efforts on “Latino-dominant” worksites: farm labor, manufacturing, textiles, and the service industry.
- Community service providers and public health agencies should use English as a Second Language (ESL) classes as vehicle for focused discussion about high blood pressure, smoking, obesity and diet as risk factors for heart disease, cancer and stroke.
- Positive traditional values of the individual’s responsibility and family integrity should be conveyed in media promotion of cancer prevention programs.
- Community service providers and public health agencies should encourage use of traditional Latino high-fiber foods.

Resource Development

- Training programs for health workers on the special chronic disease prevention needs and strategies of Latinos should be implemented statewide.
- Bilingual/bicultural community health outreach workers should be utilized extensively to screen for chronic diseases and to provide prevention education.
- The Federal Public Health Service, the CDHS, and private foundations should fund pilot programs for mobile screening of migrants and other populations having difficulties in access for detection, treatment and education of hypertension, smoking, obesity, cholesterol, cancer, and diabetes.
- Training, education, hiring and promotion of bilingual/bicultural health providers and educators in California must accelerate to meet the growing needs of the Latino population.
- Tax incentives should be offered to employers to provide/allow access to chronic disease prevention instruction for employees.
- Registration fee discounts and other incentives should be offered to Mexican food vendors and other restaurants to incorporate and promote “healthy-choice” foods, to implement no-smoking policies, and provide instruction for chronic disease prevention for employees.
- Mobile mammography units should be encouraged (via tax incentives and permit discounts) to accept Medi-Cal reimbursements and initiate sliding fee scales.
- The California Occupational Safety and Health Administration (Cal OSHA) should earmark training funds for pilot programs in Spanish to decrease occupational risk of cancer.

- Growers, manufacturing plant owners, and operators of industries where cancer risk is present should be mandated to send workers to receive adequate training on cancer risk reduction on work time.
- The CDHS and/or University of California should provide special risk communication training for clinicians who serve Latinos who are at increased occupational and environmental risk for exposure to carcinogens. This should include demonstration of culturally sensitive, terminology-appropriate, literacy-level appropriate materials.

Diabetes and Other Chronic Disabling Conditions

Diabetes and Other Chronic Disabling Conditions

Rationale

Although California's Latino population is on the whole younger than the non-Latino white (NHW) population, the most rapid population growth is occurring among the Latino elderly. The elderly are the population group most vulnerable to diabetes, heart disease, cancer, arthritis, hearing impairments, and other chronic and disabling conditions.

Latinos are characterized by lower income, lower education, less likelihood to have medical insurance, and have lower levels of basic health knowledge. They consequently visit physicians less often, postpone attention for illness until severity increases, and receive fewer chronic disease screening and prevention services. In addition, Latinos are over-represented in occupations and environmental situations where increased risk of disabling injury or cancer may exist.

Diabetes is one of the most prevalent chronic conditions among Latinos. The proportion of Latino deaths from diabetes are more than double the proportion of diabetes deaths occurring among NHWs. The prevalence of diabetes in Latino adults is greater than in NHWs and greater than any ethnic groups at certain ages. As many as 50 percent of obese Latinos over the age of 40 may develop non-insulin dependent diabetes mellitus (NIDDM), and those with relatives who have diabetes have up to an 80 percent chance of developing the disease.

The predilection for diabetes among Latinos is of great scientific interest and is in need of further research. Higher rates of obesity among Mexican Americans, genetic predisposition, body fat distribution, and the effect of poverty on diet selection are among the factors thought to increase the risk of diabetes. Complications from diabetes tend to occur more frequently in Latinos due to decreased compliance with diet and medication instruction, lack of transportation or funds for care, and misunderstanding of the importance of control. Consequently, Latinos are hospitalized more frequently for diabetes than are NHWs, and suffer greatly from diabetes complications and sequellae, such as kidney failure, blindness, infections, limb amputations, and a number of other complications resulting in poor health and disability.

Health Status Objectives

Chronic Disabling Conditions

17.1b Increase years of healthy life to at least 65 years for Latinos.

(Baseline: estimated 62 years in 1980.)

Diabetes

- 17.11c** Reduce diabetes to an incidence of no more than 2.5 per 1,000 Latinos and prevalence of no more than 25 per 1000 California Latinos.

(Baseline: 2.9 per 1,000 people in 1987; 54 per 1,000 Mexican Americans in 1982-84.)

Risk Reduction Objectives

- 17.12c** Reduce overweight to a prevalence of no more than 20 percent among Latino women aged 20 and older, and no more than 15 percent among Latino adolescents aged 12 through 19.

(Baseline: 39 percent for Latinos age 20-74 in 1982-84; 15 percent for adolescents in 1976-80.)

Services and Protection Objectives

- New** Increase to 90 percent the proportion of worksites with policies and programs to protect the Latino worker from risk of injury or exposure to potential harmful substances.

(Baseline data unavailable in 1991.)

Recommendations:

Policy

- Government and private agencies should define diabetes and chronic disease mortality data for California Latinos should be broken down by country of origin and parentage.
- A CDHS Committee on Latino Chronic Disease Prevention must be formed to address and to advise public and private entities on policy, appointments and programs.
- Public and private third party payers must provide fair reimbursement for health education, preventive health screening and nutrition education.
- Universal access to preventive health care and health education services must be assured for all people in California, regardless of national origin, citizenship or employment status.
- Require all public and private agencies receiving state funds to assure access to culturally appropriate bilingual education, information and services for chronic disease prevention and control.

- The CDHS' OFP and Title X-funded clinics should provide hypertension, cancer and diabetes screening services for non-contracepting women.
- The CDHS Maternal and Child Health (MCH) Sweet Success programs must be funded for wide application to assure access for all diabetics regardless of ability to pay and without regard to pregnancy status. Spanish language capabilities and culturally appropriate materials and methods must be mandated.
- Medi-Cal and the CDHS Comprehensive Perinatal Services Project (CPSP) must assure continued funding for diabetic care beyond the term of pregnancy for any woman who develops diabetes during pregnancy.
- Medi-Cal should develop a disease prevention program for adults which features periodic screening and education for prevention and early detection of heart disease (hypertension, cholesterol, obesity, diet, smoking), cancer and diabetes, patterned after the Child Health and Disability Prevention (CHDP) Program.
- A state clearinghouse must be developed for culturally relevant, field-tested material and information on heart disease, cancer and diabetes.
- The University of California Cooperative Extension Program should provide research on and development of low-fat, lower-calorie cooking methods for traditional foods of Mexicans/Latin Americans and market such methods aggressively to restaurants and consumers.
- Private non-profit organizations involved in chronic diseases control (e. g., heart disease, cancer, diabetes, lung) should establish research about disease prevention in Latinos as their top priority activity for this decade.

Community Intervention

- Local communities must form coalitions between public and private entities to address local services and to collaborate on efforts for prevention of chronic diseases.
- Community service providers and public health agencies should build Spanish-language media contacts and mount campaigns focusing on chronic disease prevention, detection and the need for follow-up.
- Focus health education efforts on "Latino-dominant" worksites: farm labor, manufacturing, textiles, and the service industry.

- Community service providers and public health agencies should develop curriculums for use in ESL classes for focused discussion about high blood pressure, smoking, obesity, and diet as risk factors for heart disease, cancer, and stroke.
- Encourage the development of an internship/mentor program with organizations such as American Diabetes Association and local hospitals to increase the number of Latinos in the field of nutrition and diabetes research and care.

Resource Development

- Tax incentives should be offered to employers to provide/allow access to chronic disease prevention instruction for employees.
- Registration fee discounts and other incentives should be offered to Mexican food vendors and other restaurants to incorporate and promote healthy-choice foods, complete no-smoking policies, and instruction for chronic disease prevention for employees.
- Training, education, hiring and promotion of bilingual/bicultural health providers and educators in California must accelerate to meet the growing needs of the Latino population.
- Training programs for health workers on the special chronic disease prevention needs and strategies of Latinos should be implemented statewide.
- Bilingual/bicultural community health outreach workers should be utilized extensively to screen for chronic diseases and to provide prevention education.
- The Federal Public Health Service, CDHS, and private foundations should fund pilot programs for mobile screening of migrants and other populations with difficulty in access to detection, treatment and education of hypertension, smoking, obesity, cholesterol, cancer, and diabetes.
- The CDHS, the American Diabetes Association, and other involved statewide agencies should take an inventory of existing programs with special services for Latinos and fund other communities in need to develop similar programs within a coalition/consortium model.

Surveillance and Data Systems

Surveillance and Data Systems

Rationale

Stimulated by the growing number of requests to address specific questions about Latino health and health care needs, we are forced to confront a critical shortage of information about Latinos, especially about specific national-origin and ethnic groups. It is precisely because Latino national-origin and ethnic groups differ extensively in their socio-economic, demographic, and cultural backgrounds that it is unwise to treat Latinos as a single undifferentiated, or homogenous population.

The Roybal Resolution of 1976 (Public Law 94-311) gave legal and political legitimacy to the importance of including Spanish-origin identifiers in administrative and public data systems. Most units of the statistical reporting system in California have responded to this federal requirement. Despite the significant progress in recording “Hispanic” identifiers, there are substantial gaps which limit the extent to which public policy deliberations can be properly informed.

Health data, including statistics on morbidity, are important sources of information in devising public policies aimed at improving equity of access to health and social services. Similarly, services provided by State and local programs, which are often allocated on the basis of an individual’s ability to pay, rely on detailed and highly regulated eligibility criteria. Through the use of a standard set of Latino identifiers it should be possible to determine important differences in service use and health status within and across ethnic groups.

Although over seven million Latinos reside in California, epidemiological information documenting the health status of Latinos remains scarce. Despite numerous ongoing data collection efforts by the State and local government agencies, local service providers, and academicians, these potential sources of information primarily focus on the users of services. Policy development and planning for health promotion efforts require information about both users and nonusers of medical and other clinical services.

Effective social policy rests on knowledge generated from reliable and accurate data. The development of an effective statewide surveillance system constitutes the first step in establishing a comprehensive health promotion strategy for Latinos.

Objectives

- 22.1/22.4** Use a standard set of Latino identifiers on all health data collection instruments to facilitate the generation of data on Latino subgroups.
- 22.5/22.5a** Implement in all California counties a data collection and analysis system that will facilitate the periodic analysis and publishing of data needed to measure progress toward state and local health objectives for Latinos.
- New** Support current legislation (Assembly Bill 136) that requires the California Health and Welfare Agency to create an Office of Minority Health Affairs to monitor and report on health care needs of ethnic minorities.
- New** Ensure that health assessment surveys and studies conducted in California should routinely oversample Latinos living in rural and other underserved communities to improve the coverage and reliability of health data on Latinos of special public policy interest (i.e., migrant workers, elderly, children, and women).
- New** Provide training and technical assistance to decision makers in local community organizations to make these data readily available and accessible.
- New** Follow up statewide data collection efforts with educational and informational reporting on a timely basis to local communities.

Recommendations:

Policy

- The California Legislature should create an Office of Minority Health Affairs to address health care needs of Latinos and other predominately low income ethnic groups.
- The CDHS Vital Statistics Data Collection and Analysis Unit should include a sufficient sample size of rural Latinos and other subgroups of special interest when conducting surveys to assure statistical significance of findings for these groups.
- The CDHS should develop a state-wide surveillance system to track risk factors associated with diabetes and obesity among Latinos.
- A bibliography of current data collection efforts conducted by State and local government should be published and distributed widely.

- Standard ethnic identifiers should be adopted and their use mandated for local and state program reporting.
- Health status goals should be established for the Latino population by the year 2000.
- Sufficient information should be collected to make local or at least county-level estimates.

Community Intervention

- State funding should be made available to local governments to regularly conduct systematic health needs assessments among Latinos.
- Information gained from these assessments should be used to aid public health departments, school districts, and community-based health agencies to more effectively develop health promotion interventions.

Resource Development

- The CDHS should develop training programs and provide technical assistance in study design and data collection so that local community groups can effectively collect, use, and report Latino data.
- Private foundations and other potential funding sources should be encouraged to support research and health promotion efforts that focus on Latino health.
- A directory and database of locally generated studies from community-based organizations and colleges/universities should be developed.
- An advisory or steering committee composed of data users from the community, local and state government, and the university system should be established to develop a unified data system.
- The collaboration of researchers and service-providing organizations in developing state funding priorities needs to be encouraged.

Appendix A

Contributors and Reviewers of the Latino Task Force Report

Over 190 participants of the Multi-Ethnic Health Promotion Conference attended one of the four Latino Breakout Sessions where the Task Force Report was reviewed, discussed, and revised. In addition, the revised Report was further reviewed during the Summer of 1991 by the following individuals:

Almira Afshari
 Susan Alesi
 Susan Araneta
 Stanley Bassin, EdD
 Marylou Bivian
 Carla Bouchard
 Nadia Campbell
 Lucia Carias-Chan
 David Collins
 Maria Cuevas
 Cecilia DeCuir
 Fred Dominguez
 Mark Fulop
 Crystal Hayling
 Frances Lopez Hensley
 Maria Jacobo
 Gloria Johnson-Barrows
 Paul Juarez
 Mary Grace Jue
 Eric Krenz, PhD
 Vickie Krenz, PhD
 Teresa Lopez-Enns

Margaret Rose Martinez
 Enrique Medina, Jr.
 Emily Merideth
 Kathleen O'Daniels
 Paula R. Ostrofe
 Olivier Receveur
 Lorrene Ritchie
 Janine Nunez-Robinette
 Shelia Rockoff
 Violet Roefs
 Joan W. Rupp
 Anthony R. Sancho, PhD
 Miguel Sandoval
 Selfa Saucedo
 Donna Serra-Bahena
 Sue Serverin
 Jennice M. Singer
 Katharina A. Streng
 Lisa Thompson-Dolorier
 Carmen R. Villalobos
 Anne Wheelis
 Barbara Wingate

Minda de Russey and Allan B. Tangaan, both students at the University of California at Davis, researched several sections of the Report.

The front cover graphic was designed by Joan Tarika Lewis of Oakland, CA. Ms. Lewis strived to illustrate unity with her circular design of symbols from different cultures. She was impressed by the similarity between the symbols and how well they blend into one another. She commented,
"We are all closer to one another than we think."

